To the Editor:

We thank the numerous physicians who have written letters and
called us on the telephone to convey their comments regarding the
two articles on bronchoscopy practice in North America. An
overwhelming majority of letters and comments have been exceed-
ingly complimentary. Many have suggested that the ACCP survey
should be repeated within the next five years with more questions
involving bronchoscopy topics not covered in the survey. We
commend Drs Anders and Johnson for their study on the role of
fluoroscopy in transbronchial lung biopsy (TBLB). We have no
disagreement with their comments. However, we point to a survey
of 231 bronchoscopists in the United Kingdom, which noted that
the incidence of pneumothorax after TBLB was 1.8 percent when
fluoroscopy was used but significantly increased to 2.9 percent
without fluoroscopy. Our editorial stated that "we highly recom-

mend the use of fluoroscopy because of the level of confidence
it provides the bronchoscopist in selecting the maximally abnormal
areas for biopsy. Also, fluoroscopic guidance permits precise place-
mint of the forceps in the periphery of the lung for TBLB near the
pleura." We recognize the fact that in medical centers where
fluoroscopy facilities are not available to the bronchoscopist, TBLB
may have to be performed without fluoroscopy, as is the case in
many medical centers in North America and many countries. In
patients with uniformly diffuse lung disease, TBLB without fluoro-
sopic guidance can be performed because the precise localization of
the lung segment may not be important in obtaining the biopsy
specimen. However, if fluoroscopy is easily available, the bronchosco-
pist is better off using it. Although the recommendation in our
editorial is perhaps more applicable to localized infiltrates in the
periphery of the lung, the assurance provided by fluoroscopy during
and after TBLB may preclude routine post-TBLB chest roentgeno-
graphy and hospitalization. If patients are routinely subjected to
chest roentgenography (by 79 percent of ACCP survey participants)
or hospitalization (by 12 percent of ACCP survey participants) after
TBLB solely because of not using fluoroscopy (we do not imply that
routine hospitalization and chest roentgenography by the ACCP
survey participants were due to lack of fluoroscopy facilities), then
such a procedure is not cost-effective. We agree that this is an
important question and should be included in the next ACCP
survey.

The short study by Dr Berger and colleagues is praiseworthy. It
appears that they studied the acceptability by patients of topical
anesthetic agents on the oropharynx and larynx, but not the
tracheobronchial tree. We point out that topical anesthesia in
bronchoscopy involves topical application of the anesthetic agent,
in addition to nasal passage, to two different areas, namely, the
oropharyngolaryngeal structures and the tracheobronchial tree.
Once the oropharynx and larynx are adequately anesthetized, the
topical anesthetic of choice for anesthetizing the tracheobronchial
tree is lidocaine. Our review of the English-language literature
from 1966 through 1991 revealed more than 200 articles on topical
anesthesia for bronchoscopy; more than 95 percent of the articles
discussed the role of lidocaine as the main or the only topical
anesthetic. As to the topical anesthetic of choice for the oropharynx
and larynx, lidocaine and benzocaine are equally effective, but
neither is without a certain unpleasant taste. Lidocaine has a bitter
taste, whereas benzocaine produces a "hot" sensation in the throat
immediately after it is sprayed. We concur with Dr Berger and his
colleagues that topical anesthesia is an important subject and should
be included in the next ACCP survey.

Dr McCaughan's statements are exceptionally confusing and
alarming misleading and erroneous! It makes no clinical sense to
bronchoscope a patient without chest roentgenologic abnormality,
respiratory symptoms, or other indications for bronchoscopy. It is
scientifically absurd to compare chest roentgenography to supine
films of the abdomen, and bronchoscopy to colonoscopy, in the
diagnosis of cancer of the lung and colon. The fact that a patient
had a previous lung tumor is not an indication for routine periodic
bronchoscopy unless clinical, roentgenologic, cytologic (sputum),
and other findings warrant it. We are unaware of scientific evidence
to support the statement that "endobronchial tumors migrate down
the path of least resistance. . . . " If the tumor is found early and is
confined to the distal bronchus, the best treatment for non-small

cell bronchogenic carcinoma in the 1960s is surgical resection, not
laser and/or photodynamic therapy, unless the patient cannot
undergo surgical resection. The single case report on the use of
photodynamic therapy for control of hemoptysis is just that, a
solitary anecdote.

Lastly, Dr McCaughan's concluding statement is totally wrong,
unjustified, and irresponsible since nowhere in the two articles did
we state or indicate that which he alleges.

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Gunshot Wounds to the Heart
Utility of Transesophageal Echocardiography in Assessment

To the Editor:

I noted with interest the article by Brathwaite et al, which
appeared in the January 1992 issue of Chest. This was a case report
regarding multiple traumatic gunshot wounds of the heart assessed
by transesophageal echocardiography (TEE). The authors state that
"although TEE has become routine in cardiology and cardiac
surgery in many centers, its use in the cardiac trauma patient has
not been explored." I would like to bring to your attention an article
published in 1989, in which TEE together with transthoracic and
epicardial echocardiography was utilized to assess four patients
and eight mongrel dogs with intracardiac foreign bodies, some of
which were gunshot wounds. Article also concluded that TEE has
substantial utility in detecting intracardiac foreign objects resulting
from gunshot wounds.

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